Aging in Rural America: Shaping a Policy Vision for the Future

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Estimates are that some 65+ million Americans live in rural areas and significant though uneven population shifts continue to occur in non-urban areas of the country. The Rural Policy Research Institute (RUPRI) has noted that most congressional districts in the country contain some rural parts. Population shifts in rural areas have resulted in changes in the racial and ethnic characteristics of these communities due to changing immigration patterns and in response to employment opportunities. Rural minorities, however, often live in places where poverty is high, opportunity is low, and future expectations are limited.

Especially critical to rural areas is effective coordination of health and social services that largely determine the well-being of residents. These services struggle to survive, due to weak service delivery infrastructures, inadequate funding, economic under-development, undifferentiated local political institutions, and cultural barriers, which in many communities, limit residents willingness to use what services are available. For these and other reasons, policy-makers, practitioners, and service providers are placing increased emphasis on challenges and opportunities of meeting the complex health and social service needs of rural residents.

Aging in Rural Places: The World of Is

What we do know is that advancing age brings greater reliance on the integration of health care and supportive social services and clients and patients in rural areas tend to be poorer, sicker, more isolated, and face more barriers of access to care than urban counterparts. Additionally, service system delivery capacity in rural areas tends to be

under-developed in terms of quantity and quality of available service choices and alternatives.

Limited provider infrastructure in rural places creates a widely disparate supply of health and especially long-term care service options (Krout, 1998). Additionally, rural America has fewer physicians, less available technology, lower payment rates for similar services, and fewer services (Coburn and Bolda, 1999).

Rural beneficiaries spend more of their annual income on health care services, compared to urban counterparts, and are less likely to have supplemental insurance to cover cost-sharing for Medicare or prescription drugs. They purchase more medications than urban seniors, and experience higher annual out-of-pocket costs (RUPRI, 2000).

Geographic, social and cultural isolation can also play a role in creating barriers to service design and delivery. Close local familial ties shape rural interaction networks, based on mutual survival. These traditions, however, can also serve to breed a suspicion of the outside and a fear of approaching formalized medical, health and social service institutions. An inability to pay for health care exacerbates feelings of intimidation (HHS Rural Task Force, 2002).

A Policy Vision for the Future: The World of Ought-to-Be

Effecting a program of rural transformation to address the challenges listed above will require a comprehensive effort in institution-building that will enhance rural economic, social and political infrastructure, which in turn, will sustain a strengthened capacity to meet the health care and social support service needs of rural clients.

Essentially, institution-building means reinventing and renewing rural areas so that they can better position themselves in the future to meet ongoing demand for care and services (Brown, 1997). The process calls for an integrated, focused, and futuristic strategy; ongoing, and perpetuated for the long haul.

A principal priority needs to be placed on a renaissance of economic development in rural America. Service delivery infrastructure is dependent on the strength of local economics. The challenge ahead is how to motivate, inspire, and sustain the development process.

Recommendations:

* States need to take concentrated initiatives to prioritize economic development projects in rural areas, with the safety-net help of Federal government.

* State-county partnerships need to be formed in all states utilizing county associations and associations of rural mayors to form economic development laboratories; to streamline and overhaul local political institutions, city charters and the like; and to remove costly and overlapping legal and regulatory barriers to development. The local private sector is an indispensable ally.

* State legislators who do not have them need to create rural development policy committees or sub-committees within their bodies. Rural advocates will thereby have clearly definable constituent representatives to work with.

* Unincorporated places, special districts, etc., should be targeted outreach areas for training, education and information on how to grow local economies.

* All elements of the aging service delivery network - state units, AAA, and local providers - need to become advocates for economic development in an entrepreneurial mode, as they strive to serve rural clients in their areas.

Health Care

Local health and aging-related services agencies form components of a potentially significant delivery network on the local level. Staffing, planning, and program delivery efforts need to be much more coordinated and integrated. Efforts on the state and national level to prompt such local efforts should be supportive and helpful, but not overly intrusive. All service delivery in rural places is local, and local resources need to be carefully focused and directed by local people. Special attention must be directed at identifying and removing those barriers which inhibit access to health care services and delivery of social services.

Geographic isolation, weak economic systems, lack of access to service, and paucity of service providers are among the challenges policy makers face in designing service provider systems in rural places. Services need to be based on principles of equity, choice and quality. Best practices efforts in rural service delivery require inducements and incentives to providers that may not be necessary in urban areas, to address the particular challenges of meeting the service needs of older individuals in rural areas.

Recommendations:

* The Federal government needs to continue funding rural demonstration projects that focus on best practices in service delivery to rural seniors. A recent national study by the National Council on Aging documents several specific projects of best practice models and lessons to be learned from them.

* University-based Geriatric Education Centers need to continually outreach to small, rural hospitals and other rural health care practitioners in their states with training, teaching, continuing education and technical assistance intervention to upgrade skill and knowledge of health care providers.

* The national aging network, under the direction of the Administration on Aging, is strategically positioned, particularly on the local level, to forge closer ties with health care providers in rural areas. AoA can stimulate integration of the array of support services available under the Older Americans Act. Recent reauthorization priorities under the Older Americans Act provide clear mandates to target rural elderly. This goal can be enhanced by continued collaborations between the Administration on Aging and relevant federal agencies with programs and services for rural elderly. Where appropriate, memorandums of understanding should be developed.

* Best practice reform of social insurance programs such as Medicare, need to ensure parity for rural beneficiaries by providing inducements to attract provider plans to rural areas. Payment systems need to compensate adequately health care providers in rural areas, and provide incentives to increase the supply and access of providers in rural areas.

* Enhanced transportation to reach the remotest clients, medical assistance and information through technology, mobilizing caregiver support systems, and ongoing and persistent training and education for rural health care professionals are areas that should be targeted for increased funding. This is needed to continually invigorate capacity and infrastructure for service delivery.

* The recent report by the Commission on Housing and Health Facility Needs for the 21st Century recommend, among other priorities, that more support be given to Section 504 - rural home repair and modification that are critical needs. Other recommendations from the report on housing loan programs need to be studied carefully and action taken.

* The recently enacted legislation creating the Department of Homeland Security needs to be examined to ensure appropriate attention and resources are provided for rural America.

Active Life Expectancy

* All action directed at determinants of healthy and active aging in rural areas must be multi-sectoral, in view of the multiplicity of factors involved: biological, social, economic, political and environmental. These actions should also be intergenerational, meaning that they should benefit current and future aging individuals.

* Basic public health must be promoted: It is imperative to promote the health of older rural people from childhood, with lifelong programs of health promotion and disease prevention, adequate nutrition, safe drinking water, freedom from abuse, and a healthy social and physical environment.

* Aging people and their families can play an active part in their own care. Health education and information on the aging process, and on diseases common in old age, should be culturally appropriate and correspond to levels of literacy.

* Public authorities should recognize and support relatives who care for frail aging people at home, because of the often heavy physical, emotional and financial demands that such care entails.

* In rural areas, training programs are needed for family and community caregivers, health professionals and paraprofessionals. Trainers require new orientations toward: encouraging and supporting self-health-care; maintaining mobility; maintaining independence; mental health; preventing disability; coping with disabilities; and creating barrier-free environments, among others.

* Aging people in rural areas have a role in preserving the health and protective aspects of tradition, history and local culture. Their knowledge and experience give younger generations a sense of place and continuity and security. Elders' potential in these respects should be recognized and supported.

* The well-being of rural people in old age is many times determined by conditions of their lives as children and work-age adults. Old age may amplify inequalities that have persisted from earlier stages of life. Resources should therefore be focused on the most economically deprived older people-often women and the disabled. In addition, efforts should be targeted at identifying the economically deprived of all ages and develop those intervention services which will avert these individuals from aging in place in a condition of economic deprivation.

These recommendations are a suggested pathway for successful aging through quality of life for all older Americans.

Over the next decades, quality of life values need to be based on safety - the protection from abuse, crime, fraud, and exploitation in the home and community, stressing programs of education, outreach, consumer education and advocacy;
security - which involves an adequate level of financial security, meaningful retirement with honor and dignity,

spiritual and psycho-social actualization, and intergenerational bonding; opportunity - for employment, management of life choices, empowerment, autonomy and independence and responsibility; and service - which involves meaningful voluntary and community enriching choices, pro-active social interaction toward prevention of loneliness, isolation and boredom, and enrichment throughout the lifespan, adding quality of life to years and not just years to life. Such is the promise of the great declaration in Section 101 of the enduring Older Americans' Act.

Finally, rural aging should be given a high priority in the 2005 White House Conference on Aging.

Sources

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